

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 011389	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 04/11/2013
NAME OF PROVIDER OR SUPPLIER GARDENS AT LAKE CITY			STREET ADDRESS, CITY, STATE, ZIP CODE 425 CHINWORTH CT WARSAW, IN 46580		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 2-11-2013. This visit included the PSR to the Investigation of Complaint #IN00123758.</p> <p>Survey date: April 11, 2013</p> <p>Facility Number: 011389 Provider Number: 011389 AIM Number: N/A</p> <p>Survey team: Virginia Terveer, RN, TC Julie Call, RN</p> <p>Census bed type: Residential: 19 Total: 19</p> <p>Census payor type: Other: 19 Total: 19</p> <p>Sample: 6</p> <p>Gardens at Lake City of Warsaw was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure Survey and the PSR to the Investigation of Complaint #IN00123758.</p> <p>Quality Review completed on 4/12/13, by Brenda Meredith, R.N.</p>	{R 000}			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

7WK812

If continuation sheet 1 of 1